December 20, 2024

Chiquita Brooks-LaSure
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Washington, DC 20001

RE: Medicare and Medicaid Programs; CY 2025 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments

Dear Administrator Brooks-LaSure,

On behalf of the American College of Physicians (ACP), I am pleased to share our comments on the Centers for Medicare and Medicaid Services' (CMS) notice of final rulemaking regarding changes to the Medicare Physician Fee Schedule (PFS), Quality Payment Program (QPP), and other federal programs for Calendar Year (CY) 2025 and beyond. The College is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 161,000 internal medicine physicians, related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

The College is confident that these recommended changes would improve the strength of these policies and help to promote access to affordable care for Medicare patients, support efforts to improve health equity, support physicians' ability to deliver innovative care, and protect the integrity of the Medicare trust funds. The College understands that CMS is not statutorily required to provide a public comment period for a notice of final rulemaking, and we appreciate CMS taking the time to consider our feedback for CY25 and beyond. We look forward to continuing to work with CMS to implement policies that support and improve the practice of internal medicine.

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Regulatory Impact Analysis

<u>Conversion Factor</u>
ACP is disappointed that CMS's final rule includes a 2.83 percent reduction in payment rates under the PFS compared to the average for most of CY 2024. This represents the fifth straight year that the Medicare conversion factor has decreased. Unfortunately, these cuts coincide with the ongoing growth in the cost of practicing medicine, as CMS projects that the Medicare Economic Index (MEI) increase for 2025 will be 3.5 percent. ACP appreciates CMS's efforts to support internal medicine and primary care physicians providing care to Medicare patients.

ACP calls on Congress to address the Medicare PFS cuts and pass the Medicare Patient Access and Practice Stabilization Act (H.R. 10073), which provides a 4.74 percent update. The College has also urged Congress to raise the budget-neutrality threshold, allowing greater flexibility in determining service pricing adjustments without triggering across-the-board cuts in Medicare physician pay due to budget neutrality.

Valuation of Specific Codes

<u>Telemedicine Evaluation and Management (E/M) Services (CPT codes 9X075, 9X076, 9X077, 9X078, 9X079, 9X080, 9X081, 9X082, 9X083, 9X084, 9X085, 9X086, 9X087, 9X088, 9X089, 9X090, and 9X091)</u>
ACP appreciates CMS's consideration of the CPT Editorial Panel's addition of 17 new codes for reporting telemedicine E/M services. The College supports CMS's final policy to assign these CPT codes a Procedure Status indicator of "I" and use the existing O/O E/M codes currently on the Medicare telehealth services list billed with the appropriate POS code and modifier to identify the service as being furnished via audio-only communication technology. We look forward to continuing to work with CMS, the CPT Editorial Panel, and the RUC to refine these services.

ACP is deeply concerned that, absent congressional action, the statutory restrictions on geography, site of service, and clinician type will go back into effect on January 1, 2025. As noted by CMS, there are significant concerns about maintaining access to care using Medicare telehealth services. Millions of patients have utilized interactive communications technology for visits with clinicians for a broad range of health care needs for almost five years. Patients have grown accustomed over several years to wide access to telehealth services. It is critical that Congress mitigate the negative impact of the expiring telehealth flexibilities, preserve access to Medicare, and assess the magnitude of potential reductions in access, utilization, and cost.

ACP supports the expanded role of telehealth as a method of health care delivery that can enhance the patient-physician relationship, improve health outcomes, increase access to care from physicians and members of a patient's care team, and reduce medical costs. Telehealth can be an option for patients who lack access to in-person primary or specialty care due to various social drivers of health, such as a lack of transportation, paid sick leave, or insufficient work schedule flexibility to seek in-person care during the day. Current telehealth flexibilities have been instrumental in improving access to care for patients across the U.S. ACP has strongly urged Congress to pass:

S. 2016/H.R. 4189, the CONNECT for Health Act of 2023, would permanently expand access to essential telehealth services, including expanding originating sites, lifting geographic requirements for telehealth services, and allowing FQHCs and RHCs to continue providing telehealth services, and

S. 1636/H.R. 3440, the Protecting Rural Telehealth Act, and H.R. 7623, the Telehealth Modernization Act, would ensure that seniors may continue to access audio-only telehealth consults with their physician after this option expires at the end of CY 2024. ACP strongly supports using audio-only telehealth as an effective modality to address gaps in health equity. These services are instrumental for patients who do not have the requisite broadband/cellular phone networks, have privacy concerns, do not feel comfortable using video technology, or do not possess the digital literacy to use video technology.

COVID Immunization Administration (CPT code 90480)

ACP is disappointed that CMS opted not to finalize adding a single administration code (CPT code 90480) to administer new and existing COVID-19 vaccine products with an RUC-recommended work RVU of 0.25. The College understands the confusion from commenters regarding the payment rate for this code within Medicare as opposed to other measures. ACP wants to ensure that physicians who administer COVID-19 vaccinations are adequately reimbursed for their time, and we look forward to including this code in the PFS once the EUA declaration is rescinded.

Annual Alcohol Screening (HCPCS codes G0442 and G0443), Annual Depression Screening (HCPCS code G0444), and Behavioral Counseling & Therapy (HCPCS codes G0445, G0446, and G0447)

ACP supports the final CMS values and inputs for the annual alcohol screening (G0442 and G0443), annual depression screening (G0444), and behavioral counseling and therapy (G0445, G0446, and G0447) HCPCS codes. We also believe these codes may benefit from additional review in the future to recognize the intensity of these services. The College looks forward to working with CMS to consider how best to implement and maintain payment for preventive services and develop new payment policies to address this issue more comprehensively to ensure consistent access to these services.

Payment for Caregiver Training Services (CTS)

ACP believes this newly established coding and payment for caregiver training for direct care services and support will help improve the caregiver workforce and promote patients' health. The College reiterates our request for education on these codes to encourage the uptake and utilization of caregiver training codes. Caregiver training and support is an essential element of care coordination, especially when patients have complex conditions, and the College is pleased that CMS is taking steps to promote training and reimbursement.

RFI for Services Addressing Health-Related Social Needs (Community Health Integration (G0019, G0022), Principal Illness Navigation (G0023, G0024), Principal Illness Navigation-Peer Support (G0140, G0146), and Social Determinants of Health Risk Assessment (G0136))

ACP appreciates CMS's introduction of new G-codes for Community Health Integration (CHI) and Social Drivers of Health (SDOH) Risk Assessment, as well as HCPCS codes for Principal Illness Navigation (PIN) and Peer Support services, recognizing their importance in addressing social determinants and navigating complex health care needs. We commend CMS for clarifying that CHI and PIN services can be

performed by community social workers (CSWs) and other health care professionals under the supervision of billing practitioners. However, ACP encourages CMS to address the coding gaps for auxiliary personnel like CSWs, who are vital in connecting patients with community resources but cannot currently bill for these essential services. Additionally, we urge CMS to explore how community-based organizations (CBOs) collaborate with practitioners, particularly in underserved areas, to enhance access to these services.

ACP supports the consideration of osteoporosis as a high-risk condition qualifying for PIN services in appropriate cases and encourages CMS to address further the fragmentation of fracture care, particularly for osteoporosis. Exploring options such as retroactive initiating visits for CHI and PIN services and advancing coding for comprehensive post-operative management (e.g., HCPCS code GPOC1) could improve care coordination and support practitioners in delivering high-quality, patient-centered care. We look forward to continued engagement on these important topics to ensure effective implementation and support for patients and health care professionals.

Evaluation and Management (E/M) Visits

Office/Outpatient (O/O) Evaluation and Management (E/M) Visit Complexity Add-on

ACP is very pleased CMS finalized for payment, starting January 1, 2025, the O/O E/M visit complexity add-on HCPCS code G2211 when the same practitioner reports the O/O E/M vase code on the same day as an annual wellness visit (AWV), vaccine administration, or any Part B preventive service. Allowing payment for the O/O E/M visit complexity add-on code in these scenarios will support the national goal of paying for previously unaccounted resources inherent in the complexity of all longitudinal primary care office visits.

As CMS continues to refine its policy, ACP urges CMS to allow this code to be reported across all service sites, including Home or Residence E/M services that meet the requirements of the add-on code. The principles that resulted in the appropriate recognition of the additional work and other resources related to a longitudinal care relationship in primary care or the care of a patient with a serious or complex condition are identical whether the care is in the office or the patient’s home. Home care patients are typically underserved and more dependent on continuity relationships.

Enhanced Care Management

ACP supports CMS's proposed enhanced Advanced Primary Care Management (APCM) program, which will better reimburse physicians for managing patients with complex medical and social needs. By bundling existing care management codes, stratifying services by patient complexity, and introducing new HCPCS G-codes, this program recognizes the vital role of advanced primary care while reducing administrative burdens.

ACP is pleased that CMS is finalizing an increase in the valuation for Level 1 services (HCPCS code G0556) and allowing physicians and non-physician practitioners using an advanced primary care model to bill for APCM services when serving as the focal point for all needed health care services. This finalized coding and payment structure can better describe and value advanced primary care services, encouraging

primary care practice transformation, and simplifies billing and documentation requirements. Additionally, ACP appreciates CMS's steps toward hybrid payments, which support longitudinal relationships between primary care physicians and patients while driving accountable care.

ACP remains concerned that 24/7 access requirements, maintaining continuity of care with a designated physician, and ensuring real-time access to medical records place significant burdens on smaller practices, particularly in rural areas, and those not part of an ACO. We are also still troubled by the challenges of timely EHR information exchange across disparate systems and the barriers posed by the 7-day follow-up requirement, which complicate seamless care delivery. Furthermore, the introduction of new BHI payment codes raises concerns about inadequate reimbursement for services PCPs already provide, potentially exacerbating physician burnout and straining already limited resources. As CMS considers this feedback, we recommend CMS finalize the APCM services but delay implementation until CY 2026, allowing interested parties to work with CMS to effectively refine and enhance the APCM services to provide the care patients need and deserve.

RFI on Advanced Primary Care Hybrid Payment

Streamlined Value-Based Care Opportunities
ACP encourages CMS to continue exploring the inclusion of additional services, such as remote monitoring, behavioral health integration, and care coordination, into APCM payments to further support comprehensive primary care delivery. We also support CMS's focus on balancing payment systems to maintain effective accountable care relationships and recommend transparent evaluation of alternative data sources to ensure equitable and accurate hybrid payment rates for primary care.

Billing Requirements
ACP supports CMS's focus on increasing comfort with population-based payments and reducing administrative billing burdens in the final rule, building on lessons from previous primary care models. We commend the emphasis on payment stability and predictability, particularly the decision to avoid retrospective reconciliation of payments, which has been a source of practitioner frustration. We encourage CMS to carefully consider the role of non-physician clinicians in billing for advanced primary care bundles and ensure clear policies for addressing overlapping services billed by separate entities to promote equitable access and streamlined implementation.

Person-Centered Care
ACP supports CMS's focus on empowering beneficiaries and clinicians while minimizing administrative burdens associated with episode-based and longitudinal care management. We commend CMS's exploration of advanced primary care codes for increasing efficiency, enhancing patient experience, and ensuring access to telephonic and messaging-based care services. ACP recommends carefully evaluating any additional activities included in advanced primary care bundles to avoid duplication and excessive documentation requirements. We also emphasize the importance of fostering better coordination between primary care clinicians and specialists, vital for reducing costs and improving patient outcomes.

Health Equity, Social, and Clinical Risk

ACP supports CMS's focus on empowering beneficiaries and clinicians while minimizing administrative burdens in episode-based and longitudinal care management. We commend CMS's exploration of advanced primary care codes to increase efficiency, enhance patient experience, and ensure access to services such as telephonic and messaging-based care. ACP recommends that any additional activities included in advanced primary care bundles be carefully evaluated to avoid duplication and excessive documentation requirements. Additionally, we emphasize the need for mechanisms to foster better coordination between primary care clinicians and specialists, which is critical for improving patient outcomes and reducing costs.

Quality Improvement and Accountability

ACP supports CMS's efforts to enhance advanced primary care and strengthen accountable care relationships with beneficiaries. We commend CMS for seeking feedback on advanced primary care bundles to improve clinical quality and patient outcomes and reduce administrative burdens. ACP emphasizes the importance of maintaining clinician engagement, incorporating appropriate quality and experience measures, and ensuring that the "Value in Primary Care" MVP supports accountable care.

We encourage CMS to provide flexibility for smaller practices, particularly as they transition to advanced primary care models. ACP also supports waiving cost-sharing, incorporating social risk adjustments, and increasing behavioral health integration. We urge CMS to continue fee-for-service payments for specific services while increasing primary care payments and providing capacity-building support for physicians new to longitudinal care. We look forward to working with CMS on future policies to ensure equitable access to affordable, high-quality care.

Strategies for Improving Global Surgery Accuracy

ACP supports CMS's finalization of its policy to broaden how the transfer of care modifier 54 applies for all 90-day global surgical packages in any case when a clinician expects to provide only the surgical procedure portion of the global package, including, but not limited to when there's a formal, documented transfer of care or an informal, non-documented but expected transfer of care. The College also supports CMS's policy to finalize a new add-on code (HCPCS code G0559) for post-operative care services provided by a clinician other than the one who performed the surgical procedure.

ACP appreciates CMS's efforts to implement policies that more accurately reflect the time and resources involved in the post-operative follow-up visits by clinicians who weren't involved in providing the surgical procedure. As the College has previously expressed and RAND reports evidenced, there is an immense need to reevaluate the global packages to reflect the actual number of post-operative visits provided. We have supported and provided feedback on CMS's requests to evaluate E/M services regularly and comprehensively, including proposals to address the substantial overvaluation of 10- and 90-day surgical global codes. When subsets of services are overvalued, it creates widespread distortions in the RBRVS, hurts the integrity of the Medicare system, and adversely affects the primary care workforce. ACP looks forward to continuing to work with CMS to ensure it has accurate information on the resources involved in furnishing components of global surgical packages and can appropriately value the time and resources involved.

Medicare Telehealth Services

As discussed in greater detail below, ACP is deeply concerned about the expiration of telehealth flexibilities, including the originating site and geographic restrictions on December 31, 2024. As a result, most Medicare telehealth services will only be available for patients in rural areas and only when the patients are in specific medical settings. ACP continues to urge Congress to address these concerns. The College appreciates CMS's acknowledgment that the revocation of telehealth flexibilities raises concerns about access to care and appreciates the agency's mitigation efforts to finalize proposals that help address some concerns.

Changes to the Medicare Telehealth Services List/Requests to Add Services to the Medicare Telehealth Services List

The College supports the streamlined, more straightforward process for the additions, deletions, and changes to the Medicare Telehealth Services List that will begin in CY 2025. The 5-step process review outlined will create less administrative burden on submitting and reviewing services for the Medicare Telehealth Services List. We believe categorizing services as permanent or provisional will eliminate confusion from interested parties and recognize that evidence showing clinical benefit does not always occur on a linear, annual timeline.

Frequency Limitations on Medicare Telehealth Subsequent Care Services in Inpatient and Nursing Facility Settings, and Critical Care Consultations

ACP is pleased that CMS has finalized the pause in frequency limitations for certain subsequent inpatient visits, subsequent NF visits, and critical care consultations, as proposed. The College is glad that decision-making remains with physicians through CY 2025.

Audio-Only Communication Technology to Meet the Definition of "Telecommunications System"

ACP is pleased that CMS finalized its proposal to permanently change the definition of an interactive telecommunications system to include two-way, real-time audio-only communication technology for any Medicare telehealth service furnished to a beneficiary in their home. The College has advocated for permanent, expanded telehealth flexibilities over the past few years since the start of the COVID-19 PHE. This expanded definition will be especially beneficial to reaching patients who live in rural areas, lack broadband access, are elderly, and otherwise have barriers to traditional, in-office visits. Additionally, we hope this will increase access to behavioral and mental health services to traditionally underserved populations who might only have access to audio-only technology.

Distant Site Requirements

ACP is pleased that CMS has finalized, as proposed, the flexibility in allowing practitioners to use their enrolled practice location rather than their home address when providing Medicare telehealth services from their home through CY 2025. We urge CMS to make this flexibility permanent, as the College supports patients' and doctors' safety and privacy.

Proposal to Extend Definition of "Direct Supervision" to Include Audio-Video Communications Technology Through 2025

ACP is glad to see that CMS finalized, as proposed, to temporarily continue to define direct supervision to permit the presence and "immediate availability" of the supervising practitioner through real-time audio and visual interactive telecommunications through CY 2025. Though we applaud CMS for this flexibility through CY 2025, we continue to advocate for permanent direct supervision flexibility. The College believes that clinicians should be able to supervise staff virtually and remains concerned that ending this flexibility will mandate synchronous supervision, which the College opposes, as it unnecessarily burdens supervisors by requiring them to be physically present.

Proposal to Permanently Define "Direct Supervision" to include Audio-Video Communications Technology for a Subset of Services

ACP is pleased that some specific incident-to-services will be changed permanently to allow online supervision, as proposed. However, as mentioned above, ACP continues to urge CMS to make direct supervision flexibility permanent for all services so that physicians can decide for themselves what is appropriate.

Teaching Physician Billing for Services Involving Residents with Virtual Presence

ACP is pleased to see CMS finalize, as proposed, to continue the current policy to allow teaching physicians to bill for virtually furnished services involving residents through December 31, 2025. As a physician organization, the College is significantly invested in medical education and is pleased with CMS's efforts to compensate teaching physicians for their work with future generations of medicine.

Advancing Access to Behavioral Health Services

Payment for Digital Mental Health Treatment (DMHT) Devices

ACP is pleased that CMS has finalized payment for the three new HCPSC codes, G0552, G0553, and G0554, for DMHT devices. We are hopeful that this will enable primary care physicians to continue providing behavioral health services for patients, as the demand for these services continues to rise and inability to access mental health services remains a barrier to receiving care. The College also thanks CMS for addressing patient privacy and cybersecurity concerns with these devices and outlining the cybersecurity steps required for FDA approval. ACP looks forward to future partnerships and collaboration with CMS as we further integrate behavioral health services into primary care.

Interprofessional Consultation Billed by Practitioners Authorized by Statute to Treat Behavioral Health Conditions

ACP thanks CMS for finalizing HCPCS G0546-G0551 codes as proposed for all practitioners to bill for interprofessional consultations. We hope these codes will further promote behavioral health integration and care coordination. The College encourages CMS to continually work towards adequate and accurate reimbursement for behavioral health services.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

Direct Supervision via Use of Two-way Audio/Visual Communications Technology

ACP is pleased that CMS is finalizing as proposed to maintain the virtual presence flexibility temporarily; that is, the presence of the physician (or other practitioner) would include virtual presence through audio/video real-time communications technology (excluding audio-only) through December 31, 2025. ACP supports including virtual communications in the definition of "immediate availability" for actions requiring direct supervision in RHCs and FQHCs, aligning with the PFS. While we are pleased that this definition has been expanded, we again are disappointed that these changes are not permanent. Furthermore, the College believes this provisioning should extend to all health care professionals, including those in RHCs and FQHCs.

Payment for Medical Visits Furnished Via Telecommunications Technology

ACP agrees with CMS on how essential telecommunications technology has been for the past four years in delivering care to patients that utilize RHCs and FQHCs and that disruptions could occur if only in-person medical visits received payment. The College is appreciative of the flexibilities granted by CMS over the past few years and is supportive of the decision to continue payment for medical visit services furnished via telecommunications technology. ACP supports CMS's continuing to employ a similar methodology to what is currently used (code G2025) to continue paying for these services through CY 2025. The College looks forward to continuing to provide feedback to CMS as the agency works to determine a permanent payment solution.

Payment for Preventive Vaccine Costs in RHCs and FQHCs

The College appreciates CMS allowing RHCs and FQHCs to bill for administering Part B preventive vaccines at the time of service (pneumococcal, influenza, hepatitis B, and COVID-19). These claims will initially be paid like other Part B vaccine claims, where vaccine products would be paid at 95 percent of their Average Wholesale Price (AWP), and vaccine administration would be paid according to the Fee Schedule. ACP believes this will result in timelier vaccine payments and streamline the payment of Part B vaccines across health care settings. ACP highly supports this policy change, as it will minimize the time spent completing paperwork and allow physicians more time with patients.

Conditions for Certification and Conditions for Coverage (CfCs)

ACP supports CMS's decision to no longer determine or enforce the standard of RHCs being primarily engaged in furnishing primary care services. The College agrees that this will allow for more outpatient specialty services through increased flexibility for RHCs and allow RHCs to tailor services that directly match their specific patient populations' unique needs. This can hopefully result in improved access to specialty services in rural populations and allow for more comprehensive care coordination and partnerships among clinicians. We remain confident that primary care physicians will remain an integral part of RHCs and continue to deliver high-quality care to rural populations. The College wants to guarantee that primary care physicians are getting accurately and adequately reimbursed for the services that they provide to patients, mainly when that includes behavioral health services.

Medicare Diabetes Prevention Program (MDPP)

ACP appreciates the updates to the MDPP in this final rule, particularly the alignment of definitions and delivery modes with the CDC's Diabetes Prevention Recognition Program (DPRP) Standards, which will enhance program consistency and streamline data reporting. ACP supports the continued flexibility for distance learning under the extended COVID-19 policies but encourages CMS to reconsider permitting asynchronous delivery to expand access, especially in underserved areas. Additionally, we recommend revisiting the "one in a lifetime" restriction to allow individuals who may need to reengage in prevention efforts to benefit from the program. ACP is pleased with the continued evolution of the MDPP and supports the final changes with the recommendation that purely online care be reconsidered for future inclusion.

Modifications Related to Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Programs (OTPs)

ACP appreciates that CMS finalized the proposal to permanently allow OTPs to conduct periodic assessments through audio-only communications technology when audio-video technology is unavailable to the extent such activities align with SAMHSA, DEA requirements, and other applicable requirements. Additionally, ACP is pleased that CMS finalized additional flexibilities for initiating methadone treatment via audio-video communications technology under certain circumstances.

Medicare Shared Savings Program

Eligibility Requirements and Application Procedures

ACP is pleased that CMS has eliminated the requirement for ACOs to maintain at least 5,000 assigned beneficiaries by the end of the performance year to avoid termination from the Shared Savings Program. Effective January 1, 2025, this change appropriately recognizes that the variable MSR/MLR policy provides sufficient protection against statistical variability, allowing ACOs greater flexibility to recruit clinicians and expand their beneficiary populations. ACP also supports CMS's decision to update the antitrust language in the application procedures by removing references to outdated policies and streamlining collaboration with the Federal Trade Commission (FTC) and Department of Justice (DOJ). These changes will simplify the application process, align with current enforcement practices, and enhance the operational flexibility and competitiveness of ACOs.

Proposed Revisions to the Definition of Primary Care Services

ACP is pleased that CMS has proposed revisions to the definition of primary care services used for assignment in the Shared Savings Program regulations. The inclusion of additional HCPCS and CPT codes, such as those for Safety Planning Interventions, Post-Discharge Telephonic Follow-up Contacts, Virtual Check-ins, Advanced Primary Care Management, and Cardiovascular Risk Assessment and Management, reflects the evolving scope of primary care and recognizes the importance of comprehensive and coordinated services. ACP supports this effort to align the definition with current billing and coding practices under the PFS and appreciates CMS's continued updates to ensure the Shared Savings Program remains reflective of modern care delivery.

Proposed Revisions to Criteria for ACO Models to Waive Shared Savings Program Statutory Requirements Giving Precedence for Assignment based on Beneficiary Voluntary Alignment

ACP understands CMS's rationale for finalizing its proposal regarding aligning beneficiaries to ACOs where CMS believes that the beneficiary would benefit from participating in a disease-targeted Innovation Center model. ACP would only like to stress that the choice of a beneficiary to receive care from the clinician of their choice and their ability to participate in a model that aligns with their goals and preferences should always be prioritized when implementing changes about how and where a patient receives care for their condition.

Proposal to Extend the eCQM Reporting Incentive for Meeting the Shared Savings Program Quality Performance Standard

ACP is pleased that CMS has finalized its proposal to extend the electronic clinical quality measures (eCQM) reporting incentive for performance year 2025 and subsequent years. This phased approach, which gradually adds more measures over time, appropriately supports ACOs in collecting and reporting applicable measurement data while addressing concerns about infrastructure costs. ACP also supports CMS's decision to extend the incentive to MIPS CQMs for 2025-2026, allowing ACOs to meet the quality standard by reporting all eCQMs/MIPS CQMs in the APP plus quality measure set and achieving specific performance thresholds. We appreciate CMS's efforts to balance the need for robust quality data with operational feasibility for ACOs.

Medicare Part B Payment for Preventive Services

Revised Payment Policies for Hepatitis B Vaccine Administration

ACP is pleased that CMS has finalized proposals designed to expand coverage of hepatitis B vaccinations and align payment for vaccinations in RHCs and FQHCs with the payment for the other Part B vaccines at 100 percent of reasonable cost. Allowing mass immunizers to use the roster billing process to submit hepatitis B claims should also minimize paperwork for practitioners. The College believes this will be instrumental in expanding access to this essential vaccine while reducing paperwork and streamlining payment.

Expand Colorectal Cancer Screening

ACP agrees with CMS's decision to remove the coverage of barium enema for colorectal cancer screening. More modern methods of colorectal cancer screening exist, and multiple professional medical societies also no longer recommend barium enema as a method of colorectal cancer screening.

Requirements for Electronic Prescribing for Controlled Substances for a Covered Part D Drug under a Prescription Drug Plan or an MA-PD Plan

ACP thanks CMS for finalizing their proposal to delay the inclusion of prescriptions written for covered Part D drugs for Part D eligible individuals in LTC facilities in the CMS EPCS Program compliance threshold calculation from January 1, 2025, to January 1, 2028.

CY 2025 Updates to the Quality Payment Program (QPP)

ACP encourages CMS's commitment to improving the Quality Payment Program (QPP) through meaningful updates prioritizing alignment, growth, and equity. ACP is encouraged by the continued

development of MIPS Value Pathways (MVPs) and the increased support for Advanced APM participation, as these efforts aim to reduce administrative burdens and promote high-value, cost-efficient care. ACP also appreciates CMS's exploration of new care delivery models, such as ambulatory care models linking specialist performance to payment, which promise better specialty and primary care integration. These updates represent necessary steps to enhance health care quality and foster a more equitable and efficient system for clinicians and patients.

MIPS Value Pathways Development and Maintenance

ACP supports CMS's commitment to expanding and refining the MIPS Value Pathways (MVPs) to improve care quality, safety, and equity. The addition of six new MVPs—focused on Complete Ophthalmologic Care, Dermatological Care, Gastroenterology Care, Optimal Care for Patients with Urologic Conditions, Pulmonology Care, and Surgical Care—is a positive step toward aligning quality measurement with clinical specialties and patient needs. ACP also appreciates CMS's efforts to update the MVP maintenance process to allow for greater flexibility in incorporating stakeholder feedback and aligning the MVP inventory with clear development criteria. These updates will enhance the utility of MVPs while supporting a more streamlined and collaborative approach to quality improvement.

MVP Scoring

ACP notes CMS's updates to MVP scoring policies, including using the highest score of all available population health measures and removing the requirement for MVP participants to select a population health measure at registration, as these changes simplify participation. We support aligning cost performance category scoring with traditional MIPS policies and assigning 40 points for each improvement activity that can establish transparency and consistency. Furthermore, we commend the modification to allow subgroups to report data for the Promoting Interoperability performance category, as this is a valuable step toward accommodating diverse clinician structures in the CY 2025 performance period and beyond.

APM Performance Pathway

ACP acknowledges CMS's creation of the APP Plus quality measure set within the APM Performance Pathway, aligning with the Universal Foundation measures starting in the CY 2025 performance period. ACP appreciates the flexibility offered to MIPS-eligible clinicians, groups, or APM entities by allowing a choice between reporting the original or enhanced measure set. This approach fosters the gradual adoption of enhanced measures while aligning with the Universal Foundation's goal of streamlining and standardizing quality reporting.

MIPS Performance Category Measures and Activities

<u>Quality Performance Category</u>
ACP supports CMS's updates to the MIPS APP Plus quality measure set, particularly to exclude measures without benchmarks or that do not meet case minimum requirements from scoring, provided they are still reported to satisfy APP reporting requirements. This policy balances the need for comprehensive reporting with fairness in scoring. However, ACP acknowledges the concerns raised by many commenters regarding the mandatory reporting of all APP Plus measures, the number of required measures, and the restriction to Medicare CQMs and eCQMs for Shared Savings Program ACOs. We

encourage CMS to consider these challenges to ensure the reporting requirements remain feasible and not pose undue burdens.

Cost Performance Category

ACP appreciates introducing the six new episode-based measures for the CY 2025 period in the Cost Performance Category, particularly the Chronic Kidney Disease (CKD) and End-Stage Renal Disease (ESRD) measures, which promote early intervention. However, we encourage CMS to continue refining these measures, especially the Kidney Transplant Management measure, to ensure that it does not unintentionally negatively impact transplant outcomes. ACP also acknowledges the concerns about the Respiratory Infection and Rheumatoid Arthritis measures and supports CMS's commitment to ongoing risk adjustments and stakeholder input. We urge CMS to continue monitoring the effectiveness of these measures and consider further adjustments, particularly regarding the inclusion of ophthalmic exclusions in the Rheumatoid Arthritis measure.

Improvement Activities Performance Category

ACP supports CMS's finalization of the updates to the Improvement Activities (IA) Performance Category for CY 2025, including the introduction of two new activities, the modification of one, and the removal of four activities. We also commend the codification of seven criteria for IA removals, which will improve transparency and relevance. ACP appreciates CMS's commitment to evaluating the clinical applicability of each activity, ensuring that only unique, meaningful activities remain in the IA Inventory. We encourage CMS to provide clear rationales for future removals and retain clinically relevant activities. Additionally, we support the delayed removal of four activities and modification of one until CY 2026 to allow clinicians adequate time to adjust their reporting and budgeting.

Promoting Interoperability Performance Category

ACP encourages CMS's continued efforts to enhance public health reporting and data exchange through the Promoting Interoperability (PI) performance category's Public Health and Clinical Data Exchange objective. We commend the RFI on reducing administrative burdens for MIPS-eligible clinicians while promoting enhanced data sharing with public health agencies. While CMS does not address the feedback in this final rule, ACP encourages CMS to consider the extensive input received when exploring future policies. We also support CMS's ongoing collaboration with the CDC and ONC to strengthen public health infrastructure and improve health IT and data standards in future rulemaking.

MIPS Final Scoring Methodology

Scoring the Quality Performance Category

ACP supports CMS's modified approach to topped-out measures in specialty sets with limited measure options, including using defined benchmarks covering all deciles from 1 to 10 achievement points for the CY 2025 performance period. This change provides a fairer scoring mechanism for clinicians with constrained measure choices. ACP also supports the implementation of the Complex Organization Adjustment for virtual groups and APM Entities, recognizing it as an important step to address the unique challenges these organizations face. Applying flat benchmarks for Medicare CQMs during their first two years aligns with Shared Savings Program policies and supports a smoother transition for participants.

Scoring the Cost Performance Category

ACP supports the finalized modifications to the scoring methodology for the Cost Performance Category and CMS's introducing a cost measure exclusion policy, which should improve fairness and accuracy in assessing clinician performance starting with the CY 2024 performance period. We also acknowledge the adoption of a 75-point performance threshold for the CY 2025 performance period, aligning it with the mean of final scores from CY 2017. However, we remain cautious and stress the need for CMS to have robust support for physicians during these updates.

MIPS Payment Adjustments

ACP appreciates CMS's decision to set the MIPS performance threshold at 75 points for the CY 2025 performance period/2027 payment year, as this approach provides predictability for clinicians by maintaining consistency through CY 2027/2029. We are pleased that the data completeness threshold will remain 75 percent until 2028. We also commend the new reweighting policy for performance categories impacted by circumstances beyond a clinician's control, such as third-party intermediary issues, as it fairly considers factors like clinician awareness and corrective efforts. Additionally, ACP supports the requirement for CMS-approved survey vendors to disclose service costs for the CAHPS for MIPS Survey measure, starting in CY 2026/2028, as this will enhance cost transparency and assist clinicians in making informed decisions.

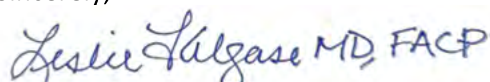
Advanced APM Proposals

ACP supports the updates to Qualifying APM Participant (QP) thresholds, which include beneficiaries receiving at least one covered service in the attribution calculation, ensuring a more comprehensive assessment of Advanced APM participation. We also acknowledge the statutory updates for the 2026 payment year, setting the APM Incentive Payment at 1.88 percent as a continued incentive for value-based care adoption. Additionally, ACP appreciates CMS's ongoing efforts to transition toward full MVP participation as part of the strategy to sunset traditional MIPS. We encourage CMS to thoughtfully incorporate feedback from the RFI on MVP adoption readiness, multispecialty group reporting, and alignment with the CMS National Quality Strategy to refine future policies that support high-quality, equitable care.

Conclusion

Thank you for the opportunity to provide feedback on CMS' finalized policy regarding changes to the CY25 PFS and QPP. ACP is confident these recommended changes would improve the strength of these polices and help promote access to affordable care for Medicare patients, while supporting physicians in their ability to deliver innovative care and protecting the integrity of the Medicare trust funds. We look forward to continuing to work with CMS to implement policies that support and improve the practice of internal medicine. Please contact Brian Outland, Ph.D., Director, Regulatory Affairs for the American College of Physicians, at boutland@acponline.org or (202) 261-4544 with comments or questions about the content of this letter.

Sincerely,



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